UNITED CONCORDIA
America's Premier Dental Insurer

State of Georgia

Group Dental Insurance Plan

Flexible Benefits Program

Underwritten By:
United Concordia Insurance Company

UNITED CONCORDIA
America's Premier Dental Insurer

UNITED CONCORDIA INSURANCE COMPANY

4401 Deer Path Road
Harrisburg, PA 17110

Dental Plan
Certificate of Insurance

Network Plan

Benefits may vary for services rendered by a Preferred Provider. See the Schedule of Benefits for coverage details.

You may contact (866) 215-2356 or visit *www.unitedconcordia.com* to obtain the name of a Preferred Provider.

Note to Florida Residents: The benefits of the policy providing your coverage are governed primarily by the state other than Florida.

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PART 1: INSURANCE SCHEDULE

Dental Expense Benefits
Employee and Dependents

Under the dental options, you may choose single or family coverage in:

- The Regular Option dental insurance plan; or
- A dental Preferred Provider Organization (PPO) Option, if you live in the metropolitan Atlanta, Augusta, Macon, Savannah, and Valdosta areas or if a PPO is available in your area.

Regular Option

Under the Regular Option, benefits are determined by the lesser of the provider's charge and either the Maximum Allowable Charge or the 90th percentile. In-network payments are based upon United Concordia's Maximum Allowable Charge. Out-of-network payments are based upon the 90th percentile, and your dentist is entitled to collect from you the difference between the amount of benefits payable by us and the provider's charge for that service.

Preferred Provider Option (PPO)

Under the PPO Option, benefits are determined by the Maximum Allowable Charge. If a Covered Person utilizes the services of a Preferred Provider, that Provider is entitled to collect from you the difference between the amount of benefits payable by United Concordia Insurance Company and the Maximum Allowable Charge. If a Covered Person utilizes the services of a Non-Preferred Provider, that Provider is entitled to collect from you the difference between the amount of benefits payable by us and the provider's charge.

Your enrollment in the PPO Option is not with a particular Dentist, but is with the PPO program. PPO dentists can discontinue their arrangement with the PPO program at any time.

If you require the services of a specialist, ask your Dentist to refer you to a PPO specialist. If a PPO specialist is not available and you receive treatment from a non-PPO specialist, we will pay the Provider at a rate equal to what the PPO Dentist would have been paid. The non-PPO specialist can charge you the difference between the amount paid by us and their normal billing amount for that service.

	Preventive (Class I)	Basic (Class II)	Major (Class III)	Orthodontia (Dependents under 19)
Deductible	None	Individual: $50** Family: Maximum $150		None
% Regular option pays	100%	80%	50%	50%
% PPO option pays	100%	90%	50%	50%
Maximum Benefit (both options)	Preventive, Basic, and Major in combination: $1,000 per Plan Year per person			$1,500 lifetime
Waiting Period for benefits-new Employees and Dependents enrolling in either option	None		On the first day of the month following six (6) months of continuous coverage	
Waiting Period for benefits-current employees not already enrolled (Late Entrant Limitations)	None	On the first day of the calendar month following 12 months of continuous coverage	On the first day of the month following 24 months of continuous coverage	

** Only one deductible applies if both Basic and Major type expenses are incurred.

PRE-DETERMINATION OF BENEFITS

Pre-determination of benefits is recommended by United Concordia Insurance Company (United Concordia) for treatment plans involving prosthetics, crowns, inlays, onlays, orthodontics, and periodontics. Whenever the estimated cost of a recommended DENTAL TREATMENT PLAN exceeds $300, it is suggested the DENTAL TREATMENT PLAN be submitted to United Concordia for its review before treatment begins. We will send notification of the benefits payable based upon the DENTAL TREATMENT PLAN. This process assures you and the Dentist that the service being performed is covered and provides you with your financial liability. In determining the amount of benefits payable, consideration will be given to the Alternate Benefit Provision that will, as determined by United Concordia, accomplish a professionally satisfactory result.

If you and the Dentist agree to a more costly method of treatment than that determined by United Concordia, the excess amount will not be paid by United Concordia.

PART 2: DEFINITIONS

Accidental Bodily Injury means a bodily injury resulting directly from an accident, not to include chewing injuries, and independently of all other cause.

Actively At Work means that you must:

1. Be able to do the normal tasks of your job on a full-time basis for a full work day on the day your insurance is to begin; and
2. Be able to do such tasks at one of your employer's normal places of business or at a location to which you must travel to do your job; and
3. Not be absent from work because of sickness, disability or temporary lay-off.

Alternative Benefit Provision (ABP) will be applied if a dental condition can be treated by means of a professionally acceptable procedure, which is less costly than the treatment recommended by the dentist. The ABP does not commit you to the less costly treatment. However, if you and the dentist choose the more expensive treatment, you are responsible for the additional charges beyond those allowed for the ABP.

Child/Children means:

Your unmarried:

1. natural and adopted children, regardless of whether they reside in the household with you; and
2. stepchildren who reside in the household with you in a normal parent-child relationship and are expected to live there for at least 180 days or more; and
3. other children for whom you have legal guardianship or custody who reside in the household with you in a normal parent-child relationship.

Your unmarried children, as defined above, must also be:

1. under nineteen (19) years of age; or
2. age nineteen (19) but less than twenty-six (26) years of age and are:
   i) dependent on you for more than 50% of support; and
   ii) full-time students in a post-secondary institution of higher learning; or
   iii) eligible to be full-time students in a post-secondary institution of higher learning but due to an injury or sickness are prevented from being a full-time student.

3. a Handicapped Child as defined later in this section.

Company means United Concordia Insurance Company.

Covered Person means you or your Dependent who is insured for DENTAL EXPENSE BENEFITS.

Covered Service(s) means a service or supply specified in this certificate for which benefits will be covered subject to the Exclusions and limitations listed in PARTS 5 and 6, when rendered by a dentist, or any other duly licensed dental practitioner under the scope of the individual's license when state law requires independent reimbursement of such practitioners.

Dental Emergency is an acute condition occurring suddenly and unexpectedly, which usually includes pain, swelling or bleeding, and demands immediate professional dental services.

Dental Hygienist is someone who is currently licensed to practice dental hygiene and is acting under the supervision and direction of a Dentist.

Dental Treatment Plan means the Dentist's report of recommended treatment on a form satisfactory to us which:

1. Itemizes the dental procedures and charges required for the necessary care of the mouth;
2. Lists the provider's charge for each procedure; and
3. Is accompanied by supporting x-rays and any other appropriate diagnostic materials as required by us.

Dentally Necessary means a dental service or procedure is determined by a dentist to either establish or maintain a patient's dental health based on the professional, diagnostic judgment of the dentist and the prevailing standards of care in the professional community. The determination will be made by the dentist in accordance with guidelines established by the Company. When there is a conflict of opinion between the dentist and the Company on whether or not a dental service or procedure is Dentally Necessary, the opinion of the Company will be final.

Dentist is someone who is currently licensed to practice dentistry and is acting within the scope of his or her license.

Department means any employing entity that is defined by state law as having employees eligible to participate in the Flexible Benefit Plan.

Dependent means:
1. Your spouse, if you are not legally separated or divorced; or
2. Your Child.

Eligible Employee means someone who:
1. Completes the waiting period (described in the "Date of Eligibility" section); and
2. Is a full-time Employee of the State of Georgia, or a State agency. "Full-time" means someone who works at least 30 hours a week, on a continuous basis, and whose employment is expected to last at least nine (9) months. The following are certain categories of employees specifically excluded: student, seasonal, part-time, short-term and sheltered-workshop;
3. Is a public school teacher who is employed in a professionally certificated capacity, works half-time or more and is not considered a "temporary" or "emergency" employee;
4. Is an Employee of a local school system who holds a non-certificated position and who is eligible to participate in the Teachers Retirement System or its local equivalent and working at least 17.5 hours a week (or 60% of the time necessary to carry out the duties of the position if that's more than 17.5 hours); and
5. Is an Employee who is eligible to participate in the Public School Employee Retirement System as defined by Paragraph 20 of Section 47-4-2 of the Official Code of Georgia, Annotated and who works at least 17.5 hours a week (or 60% of the time necessary to carry out the duties of the position).

Employer (Eligible Employer) means the State of Georgia (State Merit System and Departments).

Experimental or Investigative means the use of any treatment, procedure, facility, equipment, drug, or drug usage device or supply which the Company, determines is not acceptable standard dental treatment of the condition being treated, or any such items requiring federal or other governmental agency approval which was not granted at the time the services were rendered. The Company will rely on the advice of the general dental community including, but not limited to dental consultants, dental journals and/or governmental regulations, to make this determination. Drug usage that has not

been approved by the Federal Food and Drug Administration for a particular indication and is recognized for treatment of the indication in at least one standard compendium shall not be considered Experimental or Investigative.

Full-time Student means a Child who:

1. Is enrolled since attaining age 19 in a post-secondary institution of higher learning for five (5) calendar months or more in each plan year; or
2. Is eligible to be so enrolled but is prevented from being so enrolled due to sickness or injury.

Functioning Natural Tooth means that part of the tooth that is formed by the human body that:

1. Maintains arch length space;
2. Is utilized in the masticatory function; and
3. Is adequately supported by the surrounding structures.

Handicapped Child means a Child who may be insured beyond the applicable age limit shown in the definition of Child, as long as:

1. Such a Child is:
   a) unmarried;
   b) incapable of self-sustaining employment by reason of:
      i) mental retardation; or
      ii) physical handicap;
   c) dependent upon you for support and maintenance; and
   d) insured:
      i) under the policy upon attaining age 19; or
      ii) under the policy prior to or upon attaining age 26, if such Child is a Full-time Student; or
      iii) as a handicapped child under a Group Dental Insurance Plan of your Employer immediately prior to the date on which your Employer became an Eligible Employer; and
2. At the following times, you submit on the Child's behalf Proof of such incapacity and dependency:
   a) initially, within 90 days of whichever of the following dates is applicable:
      i) the date such Child attains age 19 if such Child is a Handicapped Child on his or her 19th birthday;
      ii) the date between the ages of 19 and 26 on which such Child incurs an injury or contracts a sickness that results in such Child becoming an Handicapped Child, if such Child is insured as a Full-time Student on such date;

iii) the date such Child attains age 26 if such Child is a Handicapped Child on his or her 26th birthday and was insured as a Full-time Student on the day immediately prior to attaining age 26; or

iv) the date on which your Employer became an Eligible Employer, if such Child meets the conditions of Item 1 above and is insured as a handicapped child under a Group Dental Insurance Plan of your Employer immediately prior to such date;

b) at such other times as we may reasonably require; and not more than once a year.

Incurred Date means a COVERED DENTAL EXPENSE will be considered incurred as follows:

1. For full or partial dentures – on the date the final insertion is completed.
2. For fixed bridges, crowns, inlays, onlays – on the date of final insertion of the teeth.
3. For root canal therapy – on the date the root canal is completed.
4. For Orthodontic Expenses:
   a) for cephalometric x-rays or study models – on the date the service was rendered; and
   b) for all other expenses – on the date the appliance or bands are inserted. (See PART 4: Determination of Benefits regarding payment of Orthodontic expenses.)
5. All other services – on the date the service is provided.

Late Entrant means someone who:

1. Complies with the "Conditions of Insurability" for Dental Expense Benefits more than 31 days after he or she becomes eligible; or
2. Requests reinstatement of insurance which was terminated while he or she remained eligible for insurance under the policy.

Maximum Allowable Charge means the maximum amount we will allow for a specific Covered Service. Maximum Allowable Charges may vary depending upon the contract between the Company and the particular Preferred Provider rendering the service. Maximum Allowable Charges for Covered Services rendered by Non-Preferred Providers may be the same or higher than such charges for Covered Services rendered by Preferred Providers in order to help limit out-of-pocket costs of those choosing Non-Preferred Providers.

Non-Preferred Provider means a Dentist or other provider who has not signed a contract with us.

Open Enrollment Period is an annual period during which Employees have an opportunity to enroll or change coverage (subject to Late Entrant penalties).

Option means the plan of Dental Expense Benefits that you elect on your Option Statement and for which you have agreed to under the conditions of the Flexible Benefit Plan. Although the amount of coverage that is provided varies with each Option, both Options are subject to all terms and conditions of the Dental Expense Benefits under the policy. The same Option that you elect for yourself will also apply to your Dependents, if any.

Option Statement refers to the enrollment form through which eligible employees elect coverage through the Flexible Benefits Program. The Option Statement is generated by the Georgia Merit System and contains basic employee data, eligibility information, and premium rates. The Option Statement serves as the binding salary reduction agreement through the IRC 125, cafeteria plan.

Orthodontic Treatment means the corrective movement of teeth through bone by means of an active appliance to correct a malocclusion of the mouth.

Orthodontic Treatment Plan means the Dentist's report of recommended or planned Orthodontic Treatment on a form satisfactory to us which:

1. Itemizes the orthodontic procedures and charges required for correction of a malocclusion;
2. Lists the provider's charge for each procedure; and
3. Is accompanied by supporting x-rays and any other appropriate diagnostic materials as required by us.

Plan Year is your benefit year during which deductibles and maximums are calculated while covered under the plan.

Preferred Provider means a Dentist or other provider who has entered into a contract with us.

PPO means Preferred Provider Organization.

Proof means any information that is:

1. Required by us under the terms of the policy; and
2. Satisfactory to us.

United Concordia Insurance Company means United Concordia Insurance Company, Harrisburg, Pennsylvania.

We (we, us, Our, our) means United Concordia Insurance Company.

You (you, Your, your) means the Employee.

PART 3: EMPLOYEE AND DEPENDENT COVERAGE ELIGIBILITY

Date of Eligibility (Waiting Period)

If you enroll for Dental Insurance under either the Regular Option or the PPO Option when you are first eligible (the hire date as determined by your Employer or the Initial Open Enrollment Period for that Option):

1. You and your eligible Dependents will be eligible for insurance for Preventive (Class I) and Basic (Class II) expenses on the first day of the calendar month following one (1) full month of employment, and
2. You and your eligible Dependents will be eligible for insurance for Major (Class III) expenses on the first day of the month following six (6) months of coverage, and
3. Your eligible dependent Children (under age 19) will be eligible for insurance for Orthodontic expenses on the first day of the month following six (6) months of coverage, and
4. A new dependent is automatically insured on the date of acquisition of new dependent if you already have family coverage.

If you do not enroll for Dental Insurance when you are first eligible, you will be considered a Late Entrant with respect to Employee Insurance and you will be subject to the Limitation on Late Entrants Section.

If you elect to enroll in an Option and subsequently elect to enroll in another Option, you will not be required to satisfy a new waiting period with respect to Major (Class III) and Orthodontic expenses.

Conditions of Insurability

You may enroll for single coverage or you may enroll for family coverage. If you enroll for single coverage, you are the only person covered under the policy. If you enroll for family coverage, you and your eligible dependents are covered under the policy. The same Option that you elect for yourself will also apply to your dependents.

To become insured under the policy you must:

1. Complete and sign the Option Statement; and
2. Make any required contribution toward the cost of the insurance as agreed to under the conditions of the Flexible Benefit Plan.

If you submit an Option Statement more than 31 days after the date you become an Eligible Employee, you are a Late Entrant with respect to Employee Insurance and you will be subject to the "Limitation on Late Entrants" section.

Premium Payments and Leave Without Pay

Premiums for coverage must be paid in advance of coverage. Normally, premiums are paid through salary reduction in the month prior to coverage. When an Employee is not in pay status, the Employee must submit the premium payment to the Employer prior to the first of the coverage month. If you are absent from work without pay for any reason, discuss continuing your insurance with your personnel officer. If you are absent from work and are on an approved leave without pay, your insurance may be continued through the twelfth (12) calendar month after you cease work. Failure to continue your premium payments may result in Late Entrant Limitations.

Should the Employee be placed in leave without pay status after enrollment but before or on the scheduled effective date of coverage, premium payment while on leave without pay should not be made.

If you are absent from work without pay for any reason, discuss continuing your insurance with your personnel officer.

Coverage Effective Date

If you meet the Conditions of Insurability, your coverage under the policy shall become effective on the later of:

1. The date of eligibility, provided you are Actively At Work. If you are not Actively At Work on that day, the coverage will begin:
   a) the day that you return to work; or
   b) on the date of eligibility if it is your scheduled day off and that you were Actively At Work on the preceding scheduled work day.
2. The first day of the plan year, provided you are Actively At Work, following the initial Open Enrollment Period for either the Regular Option or the PPO Option, if you completed, signed and submitted the Option Statement during such Open Enrollment Period; or
3. The first day of the plan year, provided you are Actively At Work, following any Open Enrollment Period subsequent to the initial Open Enrollment Period for either Option, if you complete, sign, and submit an Option Statement during such Open Enrollment Period.

If you enroll for family coverage on your eligibility date, insurance for your eligible Dependents shall be effective on the same date as the effective date of your insurance, unless:

1. The Dependent is confined in an institution providing care or treatment for physical or mental infirmities on that date;
2. If the Dependent is so confined on that date, insurance for your Dependent shall become effective on the date following dismissal from the hospital.

Limitation on Late Entrants

If you are a Late Entrant for these DENTAL EXPENSE BENEFITS, for the first 24 months of coverage your benefits will be limited as follows:

1. Benefits for the first twelve months will be limited to Preventive (Class I) COVERED DENTAL EXPENSES.
2. Benefits for the second twelve months will be limited to Preventive (Class I) and Basic (Class II) COVERED DENTAL EXPENSES.

3. No Major (Class III) Dental Expense Benefits are payable for a Covered Person until Dental Expense Benefits have been in force with respect to the limitation of late entrants for 24 consecutive months.

4. No Orthodontic Expense Benefits are payable for a Covered Person until coverage has been in force with respect to such Covered Person for 24 consecutive months. Upon completion of such 24 consecutive month period, such Covered Person will then be eligible for the lifetime maximum benefit as described in the Maximum Benefit section.

If you terminate your coverage under the policy and then later re-enroll under the plan, the above limitations will apply from the date on which your insurance is reinstated. Any time period for which your insurance was effective prior to your reinstatement cannot be used to satisfy the time limitations stated above.

Opportunities to Enroll or Change Coverage

1. If you choose not to elect coverage when first eligible (refer to the section entitled “Date of Eligibility” under PART 3) or you discontinue coverage during an Open Enrollment Period, you can elect or re-elect coverage during subsequent Open Enrollment Periods. Please refer to the Limitation on Late Entrants section on the prior page.
2. During an Open Enrollment Period, you can change coverage type and/or option. Coverage may be limited for persons added during Open Enrollment periods.
3. If you choose single coverage upon your eligibility date, you may change to family coverage upon acquisition of a newly eligible Dependent (e.g., marriage, birth, adoption). You must, however, file a written request for a change in your coverage through your department within thirty-one (31) days of such change in family status. The effective date of coverage for the Dependent(s) shall be the first of the month following the appropriate premium payment. Your newly eligible Dependents will not be subject to the Late Entrant Limitations.

4. If you lose (e.g., death, divorce, child exceeding eligible age) all eligible Dependents, you may change from family to single coverage. You must, however, file a written request for a change in your coverage through your department within ninety (90) days of such change in family status. If no change request is filed within the ninety days, a change will not be permitted until the next Open Enrollment Period.
5. If you or your Dependent(s) lose dental coverage because the employment status of your spouse changes (e.g., termination), you may enroll in single or family coverage or change from single to family coverage, if you file the request within thirty-one (31) days of the event. Persons added to coverage will not be subject to the Late Entrant Limitations.
6. If your spouse gains coverage through their change of employment, you may change from family to single coverage or discontinue family or single coverage if you file the request within ninety (90) days following the event.

Increases in Insurance

If for any reason there is an increase in the amount of insurance or benefits for which you are eligible, you will be insured for such increased amount or benefits on the date of the increase provided you are Actively At Work on that date. Otherwise, you will be insured for such increased amount or benefits on the date you are again Actively At Work.

If you are not Actively At Work on such date solely because such date was not a regularly scheduled working day, you will be deemed Actively At Work on that date.

If there is an increase in the amount of insurance or benefits for which you are eligible with respect to your Dependent, your Dependent will be insured for such increased amount or benefits on the date of the increase, subject to the Actively At Work provision mentioned above. Such Dependent, however, must not be confined in an institution providing care or treatment of physical or mental infirmities on that date. If the Dependent is so confined, such Dependent will be insured for such increased amount or benefits on the date following dismissal from the hospital.

Decreases in Insurance

If there is a decrease in the amount of insurance or benefits for which you are eligible, you will be insured for such decreased amount or benefits on the date of the decrease.

PART 4: DETERMINATION OF BENEFITS

Benefits Payable

Class I, II and III:

If during a Plan Year a Covered Person incurs COVERED DENTAL EXPENSES in excess of the Deductible (if applicable), we will pay to you a benefit equal to the applicable percentage shown in the Insurance Schedule of Preventive (Class I), Basic (Class II) and/or Major (Class III) COVERED DENTAL EXPENSES incurred in excess of the applicable Deductible, subject to the Maximum Benefit and applicable Maximum Allowable Charges.

Orthodontic (Dependent Child) Expenses:

Upon receipt of proof of claim that any Covered Person has incurred Covered Orthodontic Expenses:

1. The benefit payable will be subject to:
   a) 50% of the Covered Orthodontic Expenses; and
   b) the Lifetime Maximum Benefit; and
2. The benefit will be payable according to the following method:
   a) The initial benefit payable will:
      i) be determined by the amount charged for the diagnosis and/or placement of the bands or appliance; and
      ii) not exceed 25% of the total benefit; and
   b) any remaining benefit available for Covered Orthodontic Expenses for monthly adjustments will be payable on a monthly payment schedule as long as treatment continues and insurance is in force; and
   c) in no event will the total benefit be payable in one sum at the start of treatment.

Any benefits payable will be subject to the requirement of the Orthodontic Treatment Plan that has been reviewed and approved by us. If it is determined by us that an Alternative Benefit Provision Plan will produce a professionally satisfactory result, such benefits will be payable under the terms of the policy.

General Information

With respect to the PPO Option, if you cannot reasonably travel to a Preferred Provider and there is a Dental Emergency and you are unable to utilize the services of a Preferred Provider due to the Dental Emergency, the lesser of the provider's charge and the Maximum Allowable Charge for a given dental service in the area where the charge for the service is made will apply to services or supplies when rendered by a Non-Preferred Provider during the course of the Dental Emergency.

If you elect an Option and subsequently elect another Option, the Cash Deductible, Maximum Benefit and any other limits on amounts or time limitations on benefits payable under your current Option will be reduced by any corresponding amounts or limitations previously paid or satisfied, whether in whole or in part, under the terms of your prior Options.

Deductible

A deductible is the amount the insured is required to pay each Plan Year before any Dental Expense Benefits are payable.

The Per Person Deductible per Plan Year for Basic (Class II) and/or Major (Class III) Covered Expenses is shown in the Insurance Schedule. The amounts to be applied to meet the Deductible must be charges for COVERED DENTAL EXPENSES.

Deductible amounts applied for your family, will not exceed in any Plan Year, the Maximum Family Deductible shown in the Insurance Schedule even if the Per Person Deductible has not been met.

Maximum Benefit

The Per Person Maximum Benefit in each Plan Year for Preventive (Class I), Basic (Class II), and Major (Class III) expenses combined is shown in PART 1: Insurance Schedule (refer to page 2).

The Plan Year Maximum Benefit applies to all periods of time the Covered Person is insured during a Plan Year regardless of any interruptions in coverage for this insurance.

The Lifetime Maximum Benefit for any Covered Person who incurs Covered Orthodontic Expenses is shown in the Insurance Schedule. The Lifetime Maximum Benefit applies to all periods of time the Covered Person is insured for DENTAL EXPENSE BENEFITS under the policy, regardless of any interruptions in coverage for the insurance.

Alternate Benefit Provision

If we determine that alternate procedures, services or courses of treatment can be performed to correct a dental condition, payment will be considered for the least costly procedure which we determine will produce a professionally satisfactory result.

Favorable Result of Treatment

Benefits will be considered only for treatment that we determine has a reasonably favorable prognosis.

Benefits After Termination of Insurance

General Information

No benefits will be available for charges incurred after a Covered Person's insurance ends except for COVERED DENTAL EXPENSES incurred for treatment that is:

1. Started while a Covered Person is insured; and
2. Finished within 90 days after the Covered Person's insurance ends.

This extension is limited to crowns, fixed bridges, inlays, onlays, veneers, full dentures, partial dentures and root canal therapy. A pre-determination for any Dental Treatment Plan does not constitute treatment started.

Orthodontic Expense Benefits

Orthodontic Expense Benefits will be paid after insurance terminates only until the end of the month in which coverage terminated. If a Dependent Child, who is a Covered Person, attains age 19, Orthodontic Expense Benefits will continue to be paid if:

1. The appliance or bands were inserted while the Dependent Child was under age 19;

2. Orthodontic Treatment continues in accordance with the ORTHODONTIC TREATMENT PLAN approved by us; and
3. You continue to be insured for DENTAL EXPENSE BENEFITS.

PART 5: COVERED DENTAL EXPENSES

For any of the dental services listed below, when those services are performed by a Dentist or Dental Hygienist and are essential, as determined by us, for the necessary dental or orthodontic care of a Covered Person, and which have a favorable prognosis, as determined by us, a COVERED DENTAL EXPENSE and COVERED ORTHODONTIC EXPENSE are:

- With respect to the Regular option, the lesser of the provider's charge and either the Maximum Allowable Charge or the 90th percentile
- With respect to the PPO option, the lesser of the provider's charge and either the Maximum Allowable Charge.

The following is a complete list of those dental services which will be considered as COVERED DENTAL EXPENSES; however, expenses that are incurred for the performance of any dental service not listed below will be considered a COVERED DENTAL EXPENSE only if we agree in writing to accept such expenses as COVERED DENTAL EXPENSES. If we so agree, the benefit that we pay will be consistent, as determined by us, with a payment for such similar COVERED DENTAL EXPENSES that would provide the least costly professionally adequate treatment.

Class I - Preventive Dental Services

Oral Examination

Benefits for oral examinations are limited to 2 routine exams in a Plan Year. Limited oral evaluations (problem focused) are limited to one per dentist per 12 months.

X-rays

Complete Series or Panorex X-rays – Complete series consist of at least 10 periapicals and may also include either two to four bitewing x-rays. Panorex x-rays are films that produce a single image of the facial structure. Benefits are limited to 1 time in any 36 consecutive month period.

Individual Periapical X-rays – These films are intended to show all of a tooth, including it's surrounding structure.

Occlusal X-rays – These films allow a Dentist to see a larger area of the maxilla (upper jaw) and mandible (lower jaw).

Extraoral X-rays – X-rays taken with the film outside of the mouth. Benefit is limited to 1 film in any 6 consecutive month period.

Bitewing X-rays – These x-rays are most commonly used to detect decay of the teeth. Benefit is limited to 1 time in any 6 consecutive month period.

Dental Prophylaxis and Fluoride Treatments

Prophylaxis means a professional teeth cleaning by a Dentist or Dental Hygienist. Benefit is limited to 2 times in 12 months.

Fluoride is used as a means of preventing tooth decay. Benefit is limited to 1 time in any 6 consecutive month period and to Covered Persons under the age of 16.

Space Maintainers for missing deciduous (baby or primary) teeth – Benefit is limited to Covered Persons under the age of 14. Benefits include all adjustments within 6 consecutive months of installation.

Biopsy – A biopsy is the surgical removal of tissue for microscopic examination.

Palliative Treatment – Minor procedures performed to relieve, not cure, emergency dental pain. Paid as a separate benefit only if no other service, except x-rays, was rendered during the visit.

Sedative Fillings – Used to relieve emergency dental pain. Paid as a separate benefit only if no other service, except x-rays, was rendered during the visit.

Class II – Basic Dental Services

Diagnostic Casts – A plaster or stone model of teeth and adjoining tissue. Benefit is limited to 1 time in any 24 consecutive month period.

Restorative Dentistry – The repairing of teeth that may be necessary as a result of tooth decay or accidental bodily injury.

Amalgam Restorations (for "Silver Filling") – Used to restore posterior teeth. Multiple restorations on 1 surface will be treated as a single filling.

Composite Restorations – A plastic, resin, acrylic or silicate filling used on anterior (front) teeth. Not covered for posterior (back) teeth.

Replacement Restorations - are limited to 1 per 12 months.

Other Restorative Procedures

Stainless Steel Crowns - Hard metal shells contoured to fit over a tooth. Used when tooth cannot be restored with filling material. Stainless Steel Crowns are limited to 1 per tooth per lifetime for age 14 years and younger.

Pin Retention – Not covered in addition to cast restorations except under unusual circumstances as determined by us. Benefit is limited to 2 pins per tooth.

Recementation – Provided for Inlays, Crowns and Bridges. Recementations by the same dentist who initially inserted the crown or bridge during the first 12 months are included in the crown or bridge benefit, then 1 per 12 months thereafter; 1 per 12 months for other than the dentist who initially inserted the crown or bridge.

Repairs to Full Dentures, Partial Dentures, Bridges – Benefit is limited to repairs or adjustments of that appliance done more than 12 months after the initial insertion.

Relining Dentures – Benefit is limited to relining done more than 12 months after the initial insertion and then not more than 1 time in any 24 consecutive month period.

Endodontics – The branch of dentistry that deals with the diagnosis and treatment of diseases of the tooth pulp and the associated periapical areas (area around the end of the root).

Pulpotomy – means a partial removal of the damaged pulp of a tooth. Benefit is limited to deciduous teeth only through age 5 on anterior teeth and age 11 on posterior molars.

Root Canal Therapy – The treatment of disease or injuries of the pulp and associated with a portion of the root of the tooth.

Root Canal Treatment and retreatment - is limited to 1 per tooth per lifetime.

Other Endodontic Procedures

Apicoectomy/Retrograde Filling – Apicoectomy is the surgical removal of the apex of a tooth root. Retrograde Filling is the placement of a filling on the tooth root upon completion of the apicoectomy.

Hemisection – is the removal of approximately one-half of a multirooted tooth.

Periodontics – The branch of dentistry dealing with the prevention, diagnosis, and treatment of diseases of the bone and gum tissue which surrounds and supports the teeth.

Scaling and Root Planing – is non-surgical treatment performed for patients with periodontal disease. Benefit is limited to 2 times per quadrant of the mouth in any 12 consecutive month period.

Provisional Splinting – Temporary or permanent stabilization of teeth that may become mobile due to periodontal disease.

Crown Lengthening – is limited to 1 per tooth per lifetime.

Periodontal Maintenance – following active periodontal therapy – 2 per 12 months in addition to routine prophylaxis.

Oral Surgery

Simple Extraction – The removal of a tooth that is fully erupted and accessible for removal.

Surgical Extraction of Impacted Teeth:

Removal of tooth (soft tissue)
Removal of tooth (partial bony)
Removal of tooth (full bony)

Root Recovery – A procedure required when the crown of a tooth has been totally resorbed from disease or parts of roots are retained over a period of time as a result of fracturing at the time of the initial extraction.

Incision and Drainage – Provided to treat a localized area of acute or chronic inflammation containing pus.

Removal of a Cyst – A cyst is a pathologic space in bone or soft tissues, containing fluid or semi-fluid material.

General Anesthesia – Benefit will be paid for as a separate procedure only when required for extraction of impacted teeth.

Sealants – Benefit is limited to Covered Persons under age 16 and to occlusal surfaces of permanent first and second molars and to 1 time per tooth.

Class III – Major Dental Services

Frenectomy – Surgical procedure that may be performed to avoid a space between two adjacent teeth, or as an aid in orthodontic treatment, to correct restricted tongue movement, or to facilitate the placing of dentures.

Major Restorative Procedures

Initial and Replacement Metallic Inlays and Onlays – Covered only when the tooth cannot be restored by silver fillings.

Replacement of Metallic Inlays and Onlays – See item 5 of Exclusions.

Porcelain Restorations (veneers and crowns) – Covered only if the tooth cannot be restored by a filling or by other means.

Initial and Replacement Crowns – A crown is a fixed restoration which covers the coronal portion of the tooth. Covered only if the tooth cannot be restored by a filling or by other means. Crowns are not covered if placed for the purpose of periodontal splinting.

Placement and Replacement of Single Crowns, Inlays, Onlays, Single and Abutment Building and Post and Cores, Bridges – is limited to 1 within 5 years of their placement.

Gold Post and Core – Used to restore teeth that have had root canal treatment and are badly broken down. Covered only for

teeth that have had root canal therapy. Posts are only covered as part of a post and core buildup.

Periodontics

Osseous Graft – Osseous (Bone) Grafts are used to replace alveolar bone that has been lost due to periodontal disease.

Soft Tissue Graft – Used to replace damaged, lost or otherwise inadequate gingival tissue.

Occlusal Adjustment – This procedure involves reshaping the occlusal (the chewing surface of a posterior tooth) surfaces of the teeth. Covered only when performed in connection with Periodontal Surgery. Benefit is limited to 1 time per area of the mouth in a 12 consecutive month period.

Gingivectomy* - Benefit is limited to 1 time per quadrant in any 24 consecutive month period.

Gingival Currettage* - Benefit is limited to 1 time per quadrant in any 24 consecutive month period.

Osseous Surgery* - Benefit is limited to 1 time per quadrant in any 24 consecutive month period.

*Only one of these procedures is covered per area of the mouth in any 24 consecutive months.

Prosthodontics – The branch of dentistry concerned with the replacement of missing natural teeth and other tissues by artificial appliances.

Initial Full or Partial Dentures – See item 8 of EXCLUSIONS.

Initial Fixed Bridges – See item 8 of EXCLUSIONS.

Replacement of Full or Partial Dentures or Fixed Bridges – is limited to 1 within 5 years of their placement.

Temporomandibular Joint Disorder (TMD) Services – are dental services necessary to treat TMD disorders. Covered Services are limited to the following: TMD films, Tomographic survey, Occlusal orthotic device, Occlusal guard, Occlusion analysis and Occlusal Adjustments.

TMD joint films are limited to 1 per 5 years.

Tomographic surveys are limited to 1 per 5 years.

Dependent Child Orthodontic Expenses

Cephalometric X-rays – X-rays that show the size, contour, architecture, density, and position of the skull bones. Benefit is limited to 1 time in any 2 year period.

Orthodontic Treatment – The dental specialty that deals with the diagnosis, prevention, and correction of irregularities of the teeth and surrounding structures. Benefit is limited to malocclusion (means "improper bite") as determined by us.

Study Models – Benefit is limited to 1 Study Model per Covered Person.

Orthodontic Expenses are limited to your Dependent Child who is under age 19.

PART 6: EXCLUSIONS

COVERED DENTAL EXPENSES do not include and no benefits are provided for:

1. Procedures which are not included in the list of COVERED DENTAL EXPENSES.
2. Procedures which we determine to be unnecessary.
3. Procedures which we determine do not have uniform professional endorsement.
4. Procedures related to the change of vertical dimension, restoration of occlusion, bite registration, or bite analysis.
5. An Alternative Benefit Provision (ABP) will be applied if a dental condition can be treated by means of a professionally acceptable procedure which is less costly than the treatment recommended by the dentist. The ABP does not commit you to the less costly treatment. However, if you and the dentist choose the more expensive treatment, you are responsible for the additional charges beyond those allowed for the ABP.
6. Implants, lost or stolen appliances, precision or semi-precision attachments, over dentures or customized prostheses, denture duplication, or other customized attachments.
7. Procedures that we determine are cosmetic in nature (e.g. bleaching, whitening).
8. The initial placement of partial or full dentures, or bridges if the prosthesis includes the replacement of teeth missing prior to the effective date of the Covered Person's coverage including congenitally missing teeth. This exclusion will not apply if the prosthesis replaces a Functioning Natural Tooth that is extracted by a Dentist while the Covered Person is insured under the policy.
9. Charges for any of the following:
   a) dental care arising out of or in the course of employment for pay or profit or which is covered by Workers' Compensation or a similar law.
   b) care, treatment, services or supplies which are furnished, paid for or reimbursable by any government or subdivision of government. This restriction will not apply:
      i) to the extent that the Covered Person is required by law to pay such charges;
      ii) to charges incurred by a veteran for a non-service connected Sickness or Injury; and
      iii) to charges incurred by retired veterans or Dependents of veterans confined in a military hospital;

c) dental care resulting from any injury sustained as a result of war, declared or undeclared, or any action of war or any resistance to armed invasion or aggression or international police action;
d) failure to keep appointments;
e) dental care resulting from any injury which is self-inflicted or not caused by an accident;
f) dental care resulting from participation in the commission of a felony;
g) dental care resulting from active participation in a riot;

The words "participation" and "riot" in the phrase "participation in a riot" will be defined as follows:

Participation – includes promoting, inciting, conspiring to promote or incite, aiding, abetting, and all forms of taking part in, but will not include actions taken in defense of public or private property, or actions taken in defense of the person of the insured, if such actions of defense are not taken against person seeking to maintain or restore law and order including but not limited to police officers and firemen.

Riot – includes all forms of public violence, disorder, or disturbance of the public peace, by three or more persons assembled together, whether or not acting with a common intent and whether or not damage to person or property or unlawful act or acts is the intent or the consequence of such disorder; and

10. Diagnostic services and treatment of jaw joint problems by any method unless specifically listed in PART 5 of the certificate. These jaw joint problems include but are not limited to such conditions as temporomandibular joint disorder (TMD) and craniomandibular disorders or other conditions of the joint linking the jaw bone and the complex of muscles, nerves and other tissues related to the joint.
11. Charges made by a Dentist or Dental Hygienist who:
    a) normally lives in the Covered Person's home; or
    b) is a member of your immediate family.

    Immediate family is limited to:
    i) you;
    ii) your spouse; and
    iii) parents, brothers, sisters or children of either you or your spouse, whether related by blood or marriage.

12. COVERED DENTAL EXPENSES incurred while insurance is not in force.
13. Charges for care, treatment, services, or supplies to the extent that any benefit is provided by Medicare.
14. Charges which are not customarily made when there is no insurance, or charges for which there is no legal obligation to pay.
15. Dental care which is not customarily performed or which is experimental in nature, or for implantology.
16. Charges for oral hygiene, a plaque control program or dietary instruction.
17. Charges for any of the following:
    a) surgery necessary to repair a Functioning Natural Tooth and tissue due to accidental injury;
    b) Alveolectomy also known as Alveoloplasty. This is a surgical procedure for recontouring alveolar structures, usually in preparation for prosthetics; and
18. Any expense covered in whole or in part under any other plan of benefits or sponsored by the Employee's Employer whether or not benefits are paid under such plans as to such expenses.
19. For hospitalization costs.
20. For prescription or non-prescription drugs, vitamins, or dietary supplements.
21. Administration of nitrous oxide, general anesthesia, except for the removal of impacted teeth, and i.v. sedation, unless specifically indicated on the Schedule of Benefits.
22. Elective procedures including but not limited to the prophylactic extraction of third molars.
23. For the following which are not included as orthodontic benefits – retreatment of orthodontic cases, changes in orthodontic treatment necessitated by patient neglect, or repair of an orthodontic appliance.
24. For congenital mouth malformations or skeletal imbalances, including, but not limited to treatment related to cleft lip or cleft palate, disharmony of facial bone, or required as the result of orthognathic surgery including orthodontic treatment.
25. For oral or maxillofacial services including but not limited to associated hospital, facility, anesthesia, and radiographic imaging even if the condition requiring these services involves part of the body other than the mouth or teeth.
26. For treatment of fractures and dislocations of the jaw.
27. For treatment of malignancies or neoplasms.
28. For house or hospital calls for dental services.
29. Preventive restorations in the absence of dental disease.

30. For training and/or appliance to correct or control harmful habits, including, but not limited to, muscle training therapy (myofunctional therapy).
31. For any claims submitted to us by you or on your behalf in excess of twelve (12) months after the date of service.

PART 7: COORDINATION OF BENEFITS (COB)

If you or your Dependents are covered by any other dental plan and receive a service covered by this plan and the other dental plan, benefits will be coordinated. This means that one plan will be primary and determine its benefits before those of the other plan and without considering the other plan's benefits. The other plan will be secondary and determine its benefits after the primary plan. The secondary plan's benefits may be reduced because of the primary plan's payment. Each plan will provide only that portion of its benefit that is required to cover expenses. This prevents duplicate payments and overpayments. Upon determination of primary or secondary liability, this Plan will determine payment.

1. The following words and phrases regarding the Coordination of Benefits ("COB") provision are defined as set forth below:

A) **Allowable Amount** is the Plan's allowance for items of expense, when the care is covered at least in part by one or more Plans covering the Member for whom the claim is made.

B) **Claim Determination Period** means a benefit year. However, it does not include any part of a year during which a person has no coverage under this Plan.

C) **Other Dental Plan** is any form of coverage which is separate from this Plan with which coordination is allowed. **Other Dental Plan** will be any of the following which provides dental benefits, or services, for the following: Group insurance or group type coverage, whether insured or uninsured. It also includes coverage other than school accident type coverage (including grammar, high school and college student coverages) for accidents only, including athletic injury, either on a twenty-four (24) hour basis or on a "to and from school basis," or group or group type hospital indemnity benefits of $100 per day or less.

D) **Primary Plan** is the plan which determines its benefits first and without considering the other plan's benefits. A plan that does not include a COB provision may not take the benefits of another plan into account when it determines its benefits.

E) **Secondary Plan** is the plan which determines its benefits after those of the other plan (Primary Plan). Benefits may be reduced because of the other plan's (Primary Plan) benefits.

F) **Plan** means this document including all schedules and all riders thereto, providing dental care benefits to which this COB provision applies and which may be reduced as a result of the benefits of other dental plans.

2. The fair value of services provided by the Company will be considered to be the amount of benefits paid by the Company. The Company will be fully discharged from liability to the extent of such payment under this provision.

3. In order to determine which plan is primary, this Plan will use the following rules.

   A) If the other plan does not have a provision similar to this one, then that plan will be primary.
   B) If both plans have COB provisions, the plan covering the Member as a primary insured is determined before those of the plan which covers the person as a Dependent.
   C) Dependent Child/Parents Not Separated or Divorced - The rules for the order of benefits for a Dependent child when the parents are not separated or divorced are:
      1) The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year;
      2) If both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time;
      3) The word "birthday" refers only to month and day in a calendar year, not the year in which the person was born;
      4) If the other plan does not follow the birthday rule, but instead has a rule based upon the gender of the parent; and if, as a result, the plans do not agree on the order of benefits, the rule based upon the gender of the parent will determine the order of benefits.
   D) Dependent Child/Separated or Divorced Parents - If two or more plans cover a person as Dependent child of divorced or separated parents, benefits for the child are determined in this order:
      1) First, the plan of the parent with custody of the child.
      2) Then, the plan of the spouse of the parent with the custody of the child; and

3) Finally, the plan of the parent not having custody of the child.
4) If the specific terms of a court decree state that one of the parents is responsible for the dental care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent will be the Secondary Plan.
5) If the specific terms of the court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the dental care expenses of the child, the plans covering the child will follow the order of benefit determination rules outlined in Section 3-C) above, titled Dependent Child/Parents Not Separated or Divorced.

E) Active/Inactive Member
1) For actively employed Members and their spouses over the age of 65 who are covered by Medicare, the plan will be primary.
2) When one contract is a retirement plan and the other is an active plan, the active plan is primary. When two retirement plans are involved, the one in effect for the longest time is primary. If another contract does not have this rule, then this rule will be ignored.

F) If none of these rules apply, then the contract which has continuously covered the Member for a longer period of time will be primary.

G) The plan covering an individual as a COBRA continuee will be secondary to a plan covering that individual as a Member or a Dependent.

4. Right to Receive and Release Needed Information - Certain facts are needed to apply these COB rules. The Company has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. Any health information furnished to a third party will be released in accordance with federal law. Each person claiming benefits under This Plan must give any facts needed to pay the claim.

5. Facility of Payment - A payment made under another plan may include an amount which should have been paid under this Plan. If it does, the Company may pay the amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan, and the Company will not pay that amount again. The term "payment made" includes

providing benefits in the form of services, in which case "payment made" means reasonable cash value of the services prepaid by the Company.

Right of Recovery

If a payment made under this Plan is in excess of the total amount required to satisfy the intent of the COB provision, we have the right to recover any excess amount from one or more of the following:

1. Any person to whom, for whom, or with respect to whom such payment is made.
2. Any other insurance company.
3. Any other organization, except the Employer.

PART 8: TERMINATION PROVISIONS

Termination of Employee and Dependents Insurance

The DENTAL EXPENSE BENEFITS coverage for you and your Dependents will automatically end on the earliest date shown below:

1. On the date you are no longer Actively At Work except that:
   a) while you are sick or injured, and in an approved leave without pay period, your employment will be deemed to continue for up to 12 months from the date your disability began, as long as premium payments are made on your behalf; and
   b) while you are on an approved leave of absence (except a leave of absence to enter military or naval service), your employment will be deemed to continue, as long as premium payments are made, for up to 12 months, unless your Employer cancels your insurance before the end of that time;
2. On the last day of the calendar month following the last month in which a premium payment is made;
3. On the date such coverage is terminated for any reason;
4. On the date such coverage is terminated for all Employees; or
5. On the date the policy terminates.

Termination of Dependents Coverage Only

The DENTAL EXPENSE BENEFITS coverage for your Dependents only will automatically cease before your Employee Insurance on the earliest of:

1. The date you fail to make any required contribution for such Dependents Coverage;
2. The date such Dependents Coverage is terminated for any reason; or
3. The date a person ceases to be a Dependent as defined in the policy, but only with respect to such person.

PART 9: CONTINUATION COVERAGE RIGHTS UNDER COBRA

This notice applies to you if you have recently become covered under the Group Dental Insurance Plan for State of Georgia Flexible Benefits Program (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.** This notice gives only a summary of your COBRA continuation coverage rights. For more information about your rights and obligations under COBRA you should contact your Flexible Benefits Program Administrator ("Program Administrator").

The Program Administrator's address is Flexible Benefits Program, Georgia Merit System, 2 Martin Luther King Jr., Drive, Suite 1016 West Tower, Atlanta, Georgia 30334. The Program Administrator is responsible for administering COBRA continuation coverage. **The party responsible for administering COBRA continuation coverage, or that party's address and telephone number, may change from time to time. For the most recent information check with the Program Administrator**

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event:' Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because either one of the following qualifying events happens:

(1) Your hours of employment are reduced, or

(2) Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because any of the following qualifying events happens:

(1) Your spouse dies;

(2) Your spouse's hours of employment are reduced;

(3) Your spouse's employment ends for any reason other than his or her gross misconduct;

(4) Your spouse becomes enrolled in Medicare (Part A, Part B, or both); or

(5) You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

(1) The parent-employee dies;

(2) The parent-employee's hours of employment are reduced;

(3) The parent-employee's employment ends for any reason other than his or her gross misconduct;

(4) The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);

(5) The parents become divorced or legally separated; or

(6) The child stops being eligible for coverage under the plan as a "dependent child, upon attainment of age 19, or 26 if a full-time student"

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Program Administrator has been **timely** notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or enrollment of the employee in Medicare (Part A, Part B, or both), the employer must notify the Program Administrator within sixty (60) days after the later of the qualifying event or loss of coverage.

Important: For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Program Administrator. The Plan requires you to notify the Program Administrator in writing within 60 days after

the later of the qualifying event or the loss of coverage, using the procedures specified in the box below. If these procedures are not followed or if the notice is not provided in writing to the Program Administrator during the 60-day notice period, any spouse or dependent child who loses coverage will NOT BE OFFERED THE OPTION TO ELECT CONTINUATION COVERAGE.

Notice Procedures: Any notice that you provide must be in writing. Oral notice, including notice by telephone, is not acceptable. You must mail your notice to the Program Administrator at Flexible Benefits Program, Georgia Merit System at this address: 2 Martin Luther King Jr., Drive, Suite 1016 West Tower, Atlanta, Georgia 30334

You may contact the Program Administrator to obtain a form, if any, used to provide notice to the Program Administrator of a qualifying event.

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state the name of the Plan (Group Dental Insurance Plan) , the name and address of the employee covered under the Plan, and the name(s) and address(es) of the qualified beneficiary (ies). Your notice must also name the qualifying event and the date it happened. If the qualifying event is a divorce, your notice must include a copy of the divorce decree.

Once the Program Administrator receives **timely** notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who **timely** elects COBRA continuation coverage, COBRA continuation coverage will begin on the date of the qualifying event. **If you or your spouse or dependent children do not elect continuation coverage within this 60-day election period, YOU WILL LOSE YOUR RIGHT TO ELECT CONTINUATION COVERAGE.**

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B. or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for

up to 18 months. There are three ways in which this 18-month period of COBRA continuation coverage can be extended.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse and dependent children if the former employee dies, or gets divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child, or a determination by the Social Security Administration, under Title II or XVI of the Social Security Act (42 U.S.C. 401 et seq. or 1381 et seq.), that a qualified beneficiary is disabled, and a description of the plan's procedures for providing such notices has been made available. In all of these cases, you must make sure that the Plan Administrator is notified in writing of the second qualifying event within 60 days of the second qualifying event. The Plan requires you to follow the procedures specified in the box above, entitled "Notice Procedures." Your notice must also name the second qualifying event and the date it happened. In the second qualifying event **if these procedures are not followed or if the notice is not provided in writing to the Program Administrator within the required 60-day period, THEN THERE WILL BE NO EXTENSION OF COBRA CONTINUATION COVERAGE DUE TO THE SECOND QUALIFYING EVENT.**

Medicare extension for spouse and dependent children

If a qualifying event that is a termination of employment or reduction of hours occurs within 18 months after the covered employee becomes entitled to Medicare, then the maximum coverage period for the spouse and dependent children will end three years from the date the employee became entitled to Medicare (but the covered employee's maximum coverage period will be 18 months).

Children born to or placed for adoption with the covered employee during COBRA period

A child born to, adopted by or placed for adoption with a covered employee during a period of continuation coverage is considered to be a qualified beneficiary provided that, if the covered employee is a qualified beneficiary, the covered employee has elected continuation coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the Plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the

employee. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements (for example, regarding age).

Alternate recipients under QMCSOs

A child of the covered employee who is receiving benefits under the Plan pursuant to a Qualified Medical Child Support Order (QMCSO) received by the Program Administrator during the covered employee's period of employment with the employer is entitled to the same rights under COBRA as a dependent child of the covered employee, regardless of whether that child would otherwise be considered a dependent.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Program Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

PART 10: RETIREE AND SURVIVING SPOUSE/DEPENDENT CONTINUATION OF COVERAGE

Employees who are eligible to participate and were enrolled in the dental option at the time of retirement on or after April 1, 1997, may be eligible for continuing their dental coverage through their retirement annuity.

Retired Employee means an employee who:

1. was enrolled under the Flexible Benefits Program dental plan with continuous coverage on or after April 1, 1997; and
2. is eligible to receive an immediate and sufficient monthly benefit from the Employees' Retirement System, Legislative Retirement System, Teachers Retirement System, Public School Employees' Retirement System, Superior Court Judges Retirement System, or District Attorney's Retirement System; and
3. elects to participate in the Flexible Benefits Program dental plan as a retiree under one of the above retirement systems.

Surviving Spouse/Dependent means someone who:

1. was covered as a Dependent by an active or Retired Employee under the Flexible Benefits Program dental plan; and
2. is eligible as a beneficiary of the active or Retired Employee for an immediate and sufficient monthly benefit from the Employees' Retirement System, Legislative Retirement System, Teachers' Retirement System, Public School Employees' Retirement System, Superior Court Judges' Retirement System, or District Attorney's Retirement System; and
3. elects to participate in the Flexible Benefits Program dental plan as a Surviving Spouse/Dependent under one of the above retirement systems; and
4. is not otherwise eligible to participate in the Flexible Benefits Program dental plan as an active Employee, or as a Dependent Child covered under another active Employee, or is eligible as an active Employee.

Eligibility

To be eligible to enroll in the dental plan as a Retired Employee or Surviving Spouse/Dependent, you must meet the definition of a Retired Employee or Surviving Spouse/Dependent, and have continuous coverage (with no lapse in coverage) under the Flexible Benefits Program dental plan. In addition, a Flexible Benefits Program "Retiree/Surviving Spouse Enrollment Form for Dental Coverage" must be completed to authorize deductions for dental coverage by the Employee's applicable retirement system.

A Retired Employee or Surviving Spouse/Dependent will be subject to certain *Terms* and *Conditions* not applicable to an active Employee, such as **not** having an annual Open Enrollment Period. However, upon the initial enrollment as a Retired Employee or Surviving Spouse/Dependent, the following changes are allowed:

1. **Change of Dental Option.** A change of option means a change between Preferred Provider Organization (PPO) and regular dental insurance coverage.
   a) at the time of enrollment, a change may be made to the PPO option or Regular option. To enroll in a PPO option, a person must live in the metropolitan Atlanta, Augusta, Macon, Savannah or Valdosta areas, or have a PPO available in their area.
   b) if a person moves from a PPO area, a change from the PPO option to the regular dental insurance option is permitted. However, once a change is made, reenrollment in the PPO option is not permitted.

2. Change of Dental Coverage Type. A change of dental coverage type means a change between Single and Family coverage. The following changes are allowed:
   a) a change from Family to Single dental coverage is allowed upon request.
   b) retirees are allowed to change from Single to Family dental coverage upon acquisition of a Dependent by marriage, birth, adoption, or for certain other changes in family status, provided the request and documentation is filed no later than 31 days following the event. Surviving Spouses/Dependents cannot change from Single to Family dental coverage.

A surviving spouse of a deceased Employee enrolled in the dental plan may elect dental coverage as a Surviving Spouse, or if the spouse is an active Employee, through payroll reduction. The surviving spouse cannot elect dual coverage under this plan.

Upon the death of an active or retired Employee, a surviving eligible Dependent Child who was covered under the family dental plan and is the principal beneficiary under one of the retirement systems may continue coverage, until such time they no longer meet the eligibility requirements. The Dependent Child may not be covered under the retiree dental provision, if covered as a Dependent Child under another active or retired Employee, or is eligible as an active Employee.

A Surviving Spouse/Dependent will be eligible for dental deductions **only** if this person is receiving an immediate and sufficient benefit from an eligible retirement system. If the annuity is insufficient, the Surviving Spouse/Dependent will be eligible for continuing coverage under the “Temporary Coverage Continuation” under PART 9 of this certificate.

PART 11: GENERAL PROVISIONS

The Policy and Application

The group policy issued to the Policyholder, together with the application of the Policyholder, is the entire contract between us and the Policyholder. All statements that the Policyholder, the Employer, or you, the Employee, make are deemed to be representations and not warranties. No written statement signed by you will be used in any legal action against you unless we give you or your representative a copy.

Changes To The Policy

We and the Policyholder can change the policy in its entirety or with respect to any or all class or classes of Employees at any time if we and the Policyholder agree in writing to make such a change. Any such change will be valid without the consent of any person other than the Policyholder and us.

All such changes will be signed by our President, Vice President, Secretary or Treasurer and countersigned by one of our registrars or our President, Vice President, Secretary or Treasurer. No agent may change or waive any of the policy provisions; nor can an agent make any agreement that would be binding on us.

Waiver of Policy Provision

If at some time we chose to waive a policy provision, we still retain the right to enforce that provision at any other time. To be effective, such waiver must be in writing and signed by a person who is authorized by us to waive such terms.

Clerical Error

Clerical errors in connection with the policy or delays in keeping records for the policy whether by us or the Policyholder:

1. Will not terminate insurance that would otherwise have been effective.
2. Will not continue insurance that would otherwise have ceased or should not have been in effect.

If appropriate, a fair adjustment of premium (or claim payment) will be made to correct the error.

Misstatement of Facts

If relevant facts about any Employer or Employee relating to this insurance are not accurate:

1. If appropriate, a fair adjustment of premium will be made.
2. The true facts will decide whether, and in what amount, and for what duration insurance is valid under the policy.

Notice

Any obligation for which we may have to give written notice will be satisfied by sending such notice to the last known address of the person or institution entitled to such notice.

Discharge of Our Responsibility

Payment made under the terms of any section of the policy will, to the extent of such payment, release us from all further obligations under the policy. We will not be obligated to see to the application of such payment.

Reimbursement

Reimbursement will be made to us for any overpayments that we may make due to any reason. Deductions may be made from future benefit payments to recover any such overpayments.

If we have reimbursed you for all or part of a payment which you or a Covered Dependent, if any, were entitled to recover from a third party, you or such Dependent must repay us at that time. Such payment must be to the extent that we have reimbursed you or such Dependent, regardless of whether your coverage or that of such Dependent is still in force on the date we recover such amount from you or such dependent.

Proofs of Claim

To aid in the determination of benefits payable, you will be required to submit all dental claims on forms satisfactory to us within 90 days of

the Incurred Date of the dental treatment. Also, we have the right to require any of the following:

1. A complete dental chart showing:
    a) extractions;
    b) missing teeth;
    c) fillings;
    d) prostheses;
    e) periodontal pocket depths; and
    f) the date of any work previously performed;
    g) for orthodontia:
        i) Full Mouth Dental X-Rays;
        ii) Cephalometric X-rays and Analysis;
        iii) Study Models;
        iv) Completion of a brief questionnaire which will specify:
            a) the degree of overjet, overbite, crowding, open bite;
            b) if the teeth are impacted in crossbite, or congentially missing;
            c) the length of treatment; and
            d) the total charge for the treatment.
2. An itemized bill for all dental care.
3. The following exhibits:
    a) x-rays;
    b) study models;
    c) laboratory and/or hospital records.
4. A dental examination at our expense by a Dentist whom we choose.
5. Any additional information we may need to process your claim.

Physical Examination and Autopsy

Except as otherwise provided in the policy, we have the right to have you or your Dependent examined as often as is reasonably necessary following the receipt of a claim and while a claim is pending, or while any payments are being made under the policy. Approval of claim for benefits and the continuation of benefits are subject to you or your Dependent's cooperation in submitting to such examination. In the case of death, we also have the right to require an autopsy as long as the law does not forbid it.

Legal Actions

For 60 days after written Proof of claim has been filed, as required by us, no legal or equitable action may be brought against us for that

claim. No action at all may be brought against us after 3 years from the date on which written Proof of claim is required.

Assignment

You cannot assign any interest in the policy unless we agree in writing to such an assignment. We have the right to determine the extent to which any assignment will be honored and the priority of such assignment. We do not assume any responsibility for the validity or sufficiency of any assignment. Any payments made under such assignment after consented to by us will discharge our liabilities under the policy, to the extent of such payments.

Workers' Compensation

This insurance does not take the place of or affect any requirement for coverage by Workers' Compensation Insurance.

Facility of Payment

We will pay you all benefits, if your Proof of claim is satisfactory to us, except in the following situations:

1. You are a minor. In such case, claim may be made by your duly appointed guardian, conservator or committee and we will pay to such person or persons; or
2. Due to physical or mental incapacity, you cannot, in our judgment, give us a valid receipt for payments. In such case, claim may be made as described in item 1; or
3. You die before we pay you. In such case, claim may be made by your executor or the administrator of your estate and we will pay to such person or persons.

If we do not pay you and claim is not made by the appropriate person designated above, we may, at our option, make payments under either or both Methods A or B below. Any decision to pay any benefits, prior to the appointment of the appropriate person designated in items 1, 2 or 3 above, is solely at our discretion, and we may choose to pay no amounts under any circumstances until such appropriate person is formally appointed.

Method A:

We may pay the whole or any part of such benefit to any institution or person on whose charges payment of the benefit is based toward the satisfaction of those charges.

Method B:

We may pay the whole or any part of such benefit:

1. To your lawful spouse, up to a cumulative amount of $1,500; or
2. If you have no lawful spouse, up to a cumulative amount of $750 to any one or more of the following relatives in the following order of priority:
   a) your child or children; or
   b) your mother or father.

Time Payment of Claims

Benefits will be paid within 15 working days after receipt of your Proof of Claim, if your Proof of Claim is satisfactory to us. If benefits are not paid within 15 working days, interest on the unpaid portion of the claim shall be paid at the rate of 18 percent per year. Interest shall accrue from the 15th day, as applicable, that all information and documentation required to process the claim was submitted.

Time Periods

All time periods referred to in the policy will begin and end at 12:01 A.M. standard time at the Employer's home office.

PART 12: HOW TO FILE A CLAIM

Pre-determination of Benefits

Pre-determination of benefits is recommended by United Concordia for treatment plans involving prosthetics, crowns, inlays, onlays, orthodontics, and periodontics. Whenever the estimated cost of a recommended DENTAL TREATMENT PLAN exceeds $300, it is suggested the DENTAL TREATMENT PLAN be submitted to United Concordia for its review before treatment begins. We will send notification of the benefits payable based upon the DENTAL TREATMENT PLAN. This process assures you and the Dentist that the service being performed is covered and provides you with your financial liability. In determining the amount of benefits payable, consideration will be given to the Alternate Benefit Provision that will, as determined by United Concordia, accomplish a professionally satisfactory result.

If you and the Dentist agree to a more costly method of treatment than that determined by United Concordia, the excess amount will not be paid by United Concordia.

Completing a Claim Form

Get a claim form from your Department personnel/payroll office or the Flexible Benefits Program. Additionally, you can download a claim form from the Georgia Merit System website at gms.state.ga.us.

Complete the form according to the instructions on the form. Include the entire identification number. Additional instructions are available from your personnel/payroll office. You may also contact us for instructions and/or questions about your claim at:

1-866-215-2356

Send (or have your dentist send) the completed claim form directly to:

United Concordia Companies, Inc.
Dental Claims
P.O. Box 69421
Harrisburg, PA 17106-9421

Appeals Procedure

If you are dissatisfied with our benefit determination on a claim, you may appeal our decision by following the steps outlined in this procedure. We will resolve your appeal in a thorough, appropriate, and timely manner to ensure that you are afforded a full and fair review of claims for benefits. Benefit determinations will be made in accordance with the plan documents and consistently among claimants. You or your authorized representative may submit written comments, documents, records and other information relating to claims or appeals. We will provide a review that takes into account all information submitted whether or not it was considered with its first determination on the claim. Any notifications by us required under these procedures will be supplied to you or your authorized representative.

Definitions

The following terms when used in this document have the meanings shown below.

"Adverse benefit determination" - is a denial, reduction, or termination of or failure to make payment (in whole or in part) based on a determination of eligibility to participate in a plan or the application of any utilization review; or a determination that an item or service otherwise covered is Experimental or Investigational or not Dentally Necessary or appropriate.

"Authorized representative" - is a person granted authority by You and the Company to act on Your behalf regarding a claim for benefit or an appeal of an adverse benefit determination. An assignment of benefits is not a grant of authority to act on Your behalf in pursuing and appealing a benefit determination.

"Relevant" - A document, record, or other information will be considered "**relevant**" to a given claim:

a) if it was relied on in making the benefit determination;
b) if it was submitted, considered, or generated in the course of making the benefit determination (even if the plan did not rely on it);
c) if it demonstrated that, in making the determination, the plan followed its own administrative processes and safeguards for ensuring appropriate decision-making and consistency;

d) or if it is a statement of the plan's policy or guidance concerning the denied benefit, without regard to whether it was relied upon in making the benefit determination.

Procedure

You or your authorized representative may file an appeal with us within 180 days of receipt of an adverse benefit determination. To file an appeal, telephone the toll-free number listed on your ID card.

We will review the claim and notify you of our decision within 60 days of the request for appeal. Any dentist advisor involved in reviewing the appeal will be different from and not in a subordinate position to the dentist advisor involved in the initial benefit determination.

Notice of the appeal decision will include the following in written or electronic form:

1. the specific reason for the appeal decision;
2. reference to specific plan provisions on which the decision was based;
3. a statement that you are entitled to receive upon request and free of charge, reasonable accessibility to and copies of all relevant documents, records, and criteria including an explanation of clinical judgment on which the decision was based and identification of the dental experts;
4. the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

Appendix A

Disclaimer: The following Privacy Notice applies to information held by the Georgia Merit System and does not apply to United Concordia Insurance Company. United Concordia's Privacy Notice applies to the administration of dental benefits under this plan.

PRIVACY NOTICE

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that covered entities, including state agencies who deal with Protected Health Information (PHI), provide you with this privacy notice. This notice pertains to those programs specifically administered by the Georgia Merit System (GMS) and where GMS may maintain various types of your PHI. The GMS understands that information about you and your family is very personal, and is committed to protecting your privacy.

This notice tells you how GMS uses and discloses information about you, and it discusses your rights to keeping this information private. Please review this notice carefully.

Overview

What is Health Insurance Portability Accountability Act?

Health Insurance Portability and Accountability Act (HIPAA) of 1996, is a federal law regarding the confidentiality and security of your Protected Health Information (PHI). It imposes new restrictions on how your health information can be used and shared and creates new rights for individuals concerning their own health information.

What is Protected Health Information?

Protected Health Information (PHI), is individually identifiable health information that is maintained or transmitted by a covered entity (i.e. a health plan). It is information related to a person's health, provision of care, or payment. Some examples may include: bills for health services; explanation of benefits statement; receipts for reimbursement from a health flexible spending account plan, and health coverage or enrollment information.

How GMS Uses and Discloses Protected Health Information

When services are contracted, GMS may disclose some or all of your information to the company, so they can perform the job GMS has contracted with them to do. To protect you, the GMS requires the company to safeguard your information in accordance with the law.

Unless you object, we may release protected health information to a friend or family member who is involved in your dental care or to someone who helps pay for your care. We may also disclose protected health information about you to an organization assisting in a disaster relief effort so that your family can be notified about your condition, status, or location.

Privacy Law Requirements

GMS is required by law to:

- Maintain the privacy of your information.
- Give you this notice of legal duties and privacy practices regarding the information maintained about you.
- Follow the terms of this notice.
- Not use or disclose any information about you without your written permission, except for the reasons given in this notice. You may revoke your permission at any time, in writing, except for the information that GMS disclosed prior to your revocation. If you cannot give your permission due to an emergency, GMS may release the information if it is in your best interest. GMS must notify you as soon as possible after releasing the information.

Your Health Information Rights

You have the following rights regarding the health information maintained by the GMS. Those rights are to:

- See and obtain a copy of your health information. An exception is information that is needed for a legal action relating to GMS.
- Ask GMS to change health information that is incorrect or incomplete. GMS may deny your request under certain circumstances.
- Request a list of the disclosures that GMS has made of your health information beginning in April 2003.

- Request a restriction on certain uses or disclosures of your health information. GMS is not required to agree with your request.
- Request that GMS communicates with you about your health in a way or at a location that will help you keep your information confidential.
- Request GMS's Privacy Officer to give you another copy of this notice, or you may obtain a copy from GMS's Web site, www.gms.state.ga.us (Under "HIPAA / Privacy").

For More Information and To Report a Problem

If you have questions and would like additional information about Protected Health Information (PHI), you may contact GMS's Privacy Officer at 404-656-2730 (Atlanta calling area) or 888-968-0490 (outside of Atlanta calling area). You may also visit GMS's Web site, www.gms.state.ga.us (Under "HIPAA / Privacy").

The GMS does not discriminate on the basis of disability in the admission or access to, or treatment of employment in its programs or activities. If you have a disability and need additional accommodations to participate in any Merit System program, please contact the GMS's with your specific request. For TDD relay service only, call: 1-800-255-0056 (text-telephone) or 1-800-255-0135 (voice).

If you believe your privacy rights have been violated:

- You may file a complaint by calling the GMS Privacy Unit at 404-656-2730 (Atlanta calling area) or 888-968-0490 (outside of Atlanta calling area), or by writing to:

Georgia Merit System
Attn: Privacy Officer
2 MLK Jr. Drive, SE
Suite 1016, West Tower
Atlanta, GA 30334

- You can file a complaint with the Secretary of Health and Human Services by writing to: Secretary of Health and Human Services, 200 Independence Ave. SW, Washington, DC 20201. For additional information, call 877-696-6775.
- You may file a grievance with the United States Office for Civil Rights by calling 866-OCR-PRIV (866-627-7748) or 886-788-4989 TTY.

There will be no retaliation for filing a complaint or grievance.
If the GMS changes its privacy practices significantly, GMS will post the new notice on its Web site at www.gms.state.ga.us (Under "HIPAA / Privacy"). This notice is effective April 14, 2003.

Underwritten By:
United Concordia Insurance Company

UNITED CONCORDIA
America's Premier Dental Insurer

www.unitedconcordia.com

SOG9804 (03/05)